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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10744

CERTIFICATE OF DEATH

10747

Reg. Dist. No. 100

Item 7. Film G190 12-7-55 et.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Chas.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>INDIAN Head</u>		<u>2 yrs</u>		TOWN <u>INDIAN Head (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Robert</u> (Middle) <u>Samuel</u> (Last) <u>BARLOW</u>				(Month) <u>Nov</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>July 19 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>Cabinet maker</u>		<u>Va</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>unk</u>				<u>Beth L. Down</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>223-05-2343</u>		<u>MRS GLADYS Whitlock</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				<u>Chronic Myocarditis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>INDIAN Head</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>2 yrs.</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>11/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>55</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank H. Desan</u>				ADDRESS (Street, city, town, state) <u>Indian Head Md</u>		DATE SIGNED <u>11-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>#=28-10</u>		<u>11-28-55</u>		<u>Oakwood Cemetery</u>		<u>Richmond Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>11/28/55</u>		<u>Julia Harey</u>		<u>HUNT FUNERAL HOME</u>		<u>WALDORF</u>	

RECEIVED

NOV 30 1955

BUREAU V. S.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD	
1955	
CERTIFICATE OF DEATH	
Name of Deceased: <i>Charles</i>	
Age: <i>2 yrs</i>	
Sex: <i>Male</i>	
Race: <i>White</i>	
Date of Birth: <i>July 11 1953</i>	
Date of Death: <i>July 11 1953</i>	
Place of Birth: <i>St. Louis, Mo</i>	
Place of Death: <i>St. Louis, Mo</i>	
Cause of Death: <i>Infantile</i>	
Signature: <i>Robert J. Smith</i>	
Title: <i>Physician</i>	
Hospital: <i>St. Louis</i>	
City: <i>St. Louis</i>	
State: <i>Mo</i>	
County: <i>St. Louis</i>	
Zip: <i>63101</i>	
Registrar: <i>John I. Brown</i>	
Signature: <i>John I. Brown</i>	
Title: <i>Registrar</i>	
Hospital: <i>St. Louis</i>	
City: <i>St. Louis</i>	
State: <i>Mo</i>	
County: <i>St. Louis</i>	
Zip: <i>63101</i>	

RECEIVED
NATIONAL BUREAU OF HEALTH
U.S. DEPARTMENT OF HEALTH
WASHINGTON, D.C.
NOV 30 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10745 CERTIFICATE OF DEATH

10748

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Farmers</u>				TOWN <u>Farmers</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George I.</u> (Middle) <u>BATEMAN</u> (Last)				(Month) <u>Nov.</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 5 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>James</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unk</u>				14. MOTHER'S MAIDEN NAME <u>Unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4/5</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Norothy Bowie, Farmers Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>332X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypostatic Pneumonia</u>				3 days			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 9, 1955</u> to <u>Nov 11, 1955</u> , that I last saw the deceased alive on <u>11/11/55</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Murray</u>				DATE SIGNED <u>11/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Rest Cemetery</u>		LOCATION (City, town, or county) <u>La Plata, Md</u>	
24. REC'D BY REGISTRAR <u>Julia H. Boney</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	
DATE <u>11/14/55</u>							

10148

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (HOME OR PLACE OF BUSINESS)

MARYLAND

CITY OF BALTIMORE

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

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DATE OF EXHUMATION

PLACE OF EXHUMATION

BUREAU V. S.

NOV 16 1955

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ENCLOSURE

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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10746 CERTIFICATE OF DEATH

10749

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>La Plata</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66</u> <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Cooksey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 22 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>11/22/55</u>		9. AGE last birthday yrs. <u>40</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>40</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Floyd Allen Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Jane Catherine Radcliffe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
761.0 IMMEDIATE CAUSE (A) <u>MECHANICAL STRANGULATION, UMBILICAL CORD</u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PRECIPITATE BREECH DELIVERY</u>						<u>INSTANTANEOUS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>APNEA (DID NOT BREATHE AFTER BIRTH)</u>						<u>40 min.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARDIAC FAILURE</u>						<u>40 min.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/22</u> , 19 <u>55</u> , to <u>11/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>55</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville Md.</u>			
DATE SIGNED <u>11/22/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>La Plata Md</u>	
24. REC'D BY REGISTRAR <u>11/22/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Bane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Funeral Home</u>		ADDRESS <u>Waldorf, Md</u>	

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10747 CERTIFICATE OF DEATH

10750

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LA PLATA</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Waldorf</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66 PHYSICIANS MEMORIAL HOSP</u>				STREET ADDRESS (If rural give location)		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>MABLE</u> (First) <u>DADE</u> (Middle) <u>DADE</u> (Last)				4. DATE OF DEATH (Month) <u>NOV</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>31 OCT 1920</u>	9. AGE last birthday <u>35</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STANLEY DADE</u>				14. MOTHER'S MAIDEN NAME <u>Nettie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Geo. Stewart, Waldorf, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>HEART FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>POST-PARTUM HEMORRHAGE</u>				<u>30 minutes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>SYPHILIS</u>				<u>5 years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 16</u>, 19<u>55</u>, to <u>16 Nov</u>, 19<u>55</u>, that I last saw the deceased alive on <u>16 Nov</u>, 19<u>55</u>, and that death occurred at <u>10:25</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>J. Wooddy, MD</u>				ADDRESS (Street, city, town, state) <u>La Plata, Maryland</u>		DATE SIGNED <u>16 Nov 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Waldorf, Md</u>	
24. REC'D BY REGISTRAR DATE <u>11/21/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Casey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>			

RECEIVED
NOV 28 1955
BUREAU V

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INSTRUCTIONS

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VS-AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10751

10748 CERTIFICATE OF DEATH

Items 8,9,11: film G 189 11-28-55 L

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Port Tobacco</i>				TOWN <i>Port Tobacco</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Henry</i> (Middle) <i>Vroom</i> (Last) <i>DeMott</i>				(Month) <i>Nov</i> (Day) <i>12</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>May 10, 1891</i>	<i>64</i> Yrs.	Months <i>6</i>	Days <i>2</i>	Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Common</i>			<i></i>		<i>Port Tobacco, Sta.</i>		<i>U.S.A.</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Jacques S. DeMott</i>				<i>Sarah F. Cartelgou</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>Yes</i>				<i></i>		<i>my Elva S. DeMott</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>						<i>5 min</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary artery - heart disease</i>						<i>1 year</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i></i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i></i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<i>8</i>		<i></i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<i></i>		<i></i>		<i></i>		<i></i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
<i></i>		<i></i>		<i></i>			
22. I hereby certify that I attended the deceased from <i>June</i> , 19 <i>53</i> , to <i>12 Nov</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12 Nov</i> , 19 <i>55</i> , and that death occurred at <i>5:25 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>A Wooddy MD</i>				ADDRESS (Street, city, town, state)		DATE SIGNED <i>14 Nov 55</i>	
M.D. <i>La Plata Md.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>11/16/55</i>		<i>Cedar Hill</i>		<i>Switland Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i></i>		<i>Jalen H Paze</i>		<i>Cruikshank Funeral Home in La Plata</i>		<i></i>	
DATE <i>11/15/55</i>							

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

10749 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10752

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Harrod</u> TOWN <u>Harrod</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Spring)</u> <u>Md.</u> TOWN <u>—</u> STREET ADDRESS (If rural, give location) <u>—</u>	
3. NAME OF DECEASED (Type or Print) <u>THOMAS WILLIAM HIGDON</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-28-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md. CHAS Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>LEWIS A. HIGDON</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY No. <u>216-10-8873</u>	
17. INFORMANT AND ADDRESS <u>CATHERINE E. HIGDON (WIFE)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>CORONARY OCCLUSION</u> Antecedent cause(s) (b) <u>SCHEROSIS</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>GEN. ART</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11-25-55</u> <u>Jan 1953</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>E. Edelen</u> (Degree or title) <u>MD</u> ADDRESS <u>Lab Plate, Md.</u> DATE SIGNED <u>11-25-55</u>			
23. BURIAL, CREMATION REMAINS (Specify) <u>Reinterment</u>		DATE THEREOF <u>11-25-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
DATE REC'D BY LOCAL REG. <u>11-25-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. F. Hills Pugh</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		ADDRESS <u>Washington DC</u>	

RECEIVED

NOV 29 1955

BUREAU V. S.

10750 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

10753

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>THOMAS</u> (Middle) <u>(Tommie)</u> (Last) <u>PHILLIPS</u>	4. DATE OF DEATH	(Month) <u>11</u> (Day) <u>20</u> (Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-17-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>2</u> yrs. If under 1 year Months <u>2</u> Days <u>3</u> If under 24 hrs. Hours <u>1</u> Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jackie Lee Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Anne Marie Dennison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>795.3</u> Immediate cause (a) <u>Unknown</u>		<u>11-20-55</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Baby found dead in bed by parents 11-20-55</u>		
(c) <u>Spent to bed well</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office building) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Bryans Road</u> (COUNTY) <u>Charles</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE <u>E. Medlen</u>	(Degree or title) <u>MD.</u>	ADDRESS <u>Laplace Rd</u>	DATE SIGNED <u>11-20-55</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>11/21/55</u>	NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak</u>	LOCATION (City, town, or county) (State) <u>Panthers Md.</u>
DATE RECD BY LOCAL REG. <u>11/21/55</u>	REGISTRAR'S SIGNATURE <u>Julius H. H. H.</u>	24. FUNERAL DIRECTOR <u>Jackie Lee Phillips</u>	ADDRESS <u>Bryans Rd. Md.</u>

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10751 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

10754

Reg. Dist. No.

1. PLACE OF DEATH— COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Newport (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Newport (rural)</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>MYRON</u> (First) <u>TIMOTHY</u> (Middle) <u>PLATER</u> (Last)		4. DATE OF DEATH <u>Nov</u> (Month) <u>7</u> (Day) <u>1955</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 9 1954</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>1</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Earl Plater</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Winters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Dorothy Plater Newport, Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>051X</u> Immediate cause (a) <u>Septicemia</u> Antecedent cause(s) (b) <u>Sore throat</u> Disease or condition, if any, giving rise to the above cause, stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12-hr</u> <u>24-hr</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>F. M. Johnson</u> M.D.		DATE SIGNED <u>7 Nov 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Newport, Md</u>	
DATE REC'D BY LOCAL REG. <u>11-9-55</u>		24. FUNERAL DIRECTOR <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>	

BUREAU V. S.

NOV 10 1965

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MARYLAND STATE DEPARTMENT OF HEALTH
10752 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10755

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>DAVID</u> (Middle) <u>Ryan</u> (Last) <u>Posey</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>19</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 28, 1940</u>
9. AGE last birthday <u>15</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Student</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wm. Howard Posey</u>		14. MOTHER'S MAIDEN NAME <u>Ryan Evelyn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Mrs. Audrey Moreland, Waldorf, Md.</u>	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
825X Immediate cause (a) <u>HEMORRHAGE</u>		<u>11-19-55</u>	
Antecedent cause(s) (b) <u>SEVERENCE LEFT JUGULAR</u>		<u>11-19-55</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>AUTO ACCIDENT</u>		<u>11-19-55</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> PLACE OF INJURY <u>Highway</u>		(CITY OR TOWN) <u>Lanham</u> (COUNTY) <u>Charles</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 19 55 10pm</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Auto accident - passenger</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from <input checked="" type="checkbox"/> natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>C. Hedeler MD</u>		DATE SIGNED <u>11-19-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Switzland, Md.</u>	
DATE REG'D BY LOCAL REG. <u>11/23/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Posey</u>	
24. FUNERAL DIRECTOR <u>Hunt & Ryan, Waldorf, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10753

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10756
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 105

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Waldorf (Rural)</u>		Life		TOWN <u>Waldorf (Charles)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary Ann Roberson</u>				<u>Nov. 25, 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>Negro</u>		<u>Single</u>		<u>Nov. 25, 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: yrs. Months Days		11. BIRTHPLACE (State or foreign country):	
						<u>Waldorf (Rural)</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>Henry Garfield Roberson</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME:			
				<u>Martha Imogene Ford</u>			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
				<u>Martha Imogene Ford Waldorf, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Generalized deformity</u>						<u>11-26-55</u>	
DUE TO <u>dwarf like with seven fingers & paper thin abd wall</u>							
Antecedent cause(s) (b) <u>abd wall</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>C. Hedden</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-26-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-26-55</u>		<u>Brown Cemetery</u>		<u>Waldorf Md</u>	
DATE REC'D BY LOCAL REG. <u>11-26-55</u>		REGISTRAR'S SIGNATURE <u>M. L. Monroe</u>		24. FUNERAL DIRECTOR <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md</u>	

20X311404

RECEIVED

NOV 28 1985

MARYLAND STATE DEPARTMENT OF HEALTH
10754 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10757

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Alton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>Rodger</u> (Middle) <u>L</u> (Last) <u>Rosier</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>Feb 2 1914</u>
9. AGE last birthday <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Annie Rosier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Harry Rosier Bel Alton</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Cerebral hemorrhage</u>		<u>11-19-55</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Fractures of ankle</u>		<u>11-19-55</u>	
(c) <u>Pedestrian hit by auto</u>		<u>11-19-55</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or place of business) OF INJURY <u>Highway 301</u> (CITY OR TOWN) <u>Bel Alton</u> (COUNTY) <u>Charles</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11</u> <u>19</u> <u>55</u> <u>PM</u>		INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Pedestrian hit by auto</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>L. Rodden</u>		DATE SIGNED <u>11-20-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-22-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St Thomas Mason</u>		LOCATION (City, town, or county) <u>Bel Alton</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>11/22/55</u>		24. FUNERAL DIRECTOR <u>Rehman Funeral Home Inc</u> ADDRESS <u>La Plata Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

NOV 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12604

CERTIFICATE OF DEATH

Reg. Dist. No. 106...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Indian Head</u>		<u>6 Yrs.</u>		<u>Indian Head Md</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Annie Ophelia Short</u>				OF DEATH: <u>11-4-55</u> <u>19</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negro</u>	<u>Widow</u>	<u>9-4-1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Maryland</u>		<u>US</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Fred Greer</u>				<u>Eliza Chun</u>			
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Helen Carter (Grandaughter)</u> <u>Pisgah Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>450.0</u>							
IMMEDIATE CAUSE (A) <u>Malnutrition</u>						<u>One Month</u>	
DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>Indefinite</u>	
(B) <u>General Arterio-Sclerosis</u>							
DUE TO							
(C) <u>Senility</u>						<u>Indefinite</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
OF INJURY		M.					
22. I hereby certify that I attended the deceased from <u>10-23-55</u> , 19....., to <u>11-4-55</u> , 19....., that I last saw the deceased alive on <u>11-4-55</u> , 19....., and that death occurred at <u>12:15</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews Md</u>				ADDRESS <u>Indian Head Md</u>		DATE SIGNED <u>11-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>11/4/55</u>		<u>Smiths Chapel</u>		<u>Pisgah Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/6/55</u>		REGISTRAR'S SIGNATURE <u>Odey Price</u>		24. FUNERAL DIRECTOR <u>Johnson - Jenkins</u>		ADDRESS <u>1702 12th St. N.W.</u>	

BUREAU V. 2

MAR 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10755

CERTIFICATE OF DEATH

10758

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>La Plata</i>				TOWN <i>Parmfret</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phy. Memorial Hosp.</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Baby Girl SIMMONS</i>				<i>11 25 1955</i>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<i>F</i>		<i>W</i>		<i>S</i>		<i>11-25-55</i>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<i>11</i>		<i>25</i>		<i>19</i>		<i>55</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>none</i>						<i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?				<i>US</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Francis S. Simmons</i>				<i>Blanche Hamilton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>Y</i>						<i>Francis S. Simmons father</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<i>PREMATURITY</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>1#6 1/2 oz</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<i>EDC. 3-16-55</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<i>11-25-55</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>11-25-55</i>				<input type="checkbox"/>		<input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-10, 1955</i>, to <i>11-25, 1955</i>, that I last saw the deceased alive on <i>11-25, 1955</i>, and that death occurred at <i>2:35</i> P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<i>E. J. Edelen</i>				<i>11-25-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>11-27-55</i>		<i>St. Jos.</i>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<i>11/28/55</i>				<i>Julia H. Barry</i>		<i>The Heart Funeral Home</i>	

10758 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10758

1. DECEASED'S NAME (Print or Type)

MARY ANN
MAY 1910
BALTIMORE, MD

2. SEX (Print or Type)
F
3. RACE (Print or Type)
W
4. DATE OF BIRTH (Print or Type)
MAY 1910
5. PLACE OF BIRTH (Print or Type)
BALTIMORE, MD

6. DATE OF DEATH (Print or Type)
MAY 1955

7. PLACE OF DEATH (Print or Type)
BALTIMORE, MD

8. CAUSE OF DEATH (Print or Type)
HEART DISEASE

9. MANNER OF DEATH (Print or Type)
NATURAL

10. SIGNATURE OF PHYSICIAN (Print or Type)
J. H. HARRIS

11. SIGNATURE OF REGISTRAR (Print or Type)
J. H. HARRIS

12. MEDICAL CERTIFICATION (Print or Type)
I, the undersigned, a duly licensed physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the deceased.

13. DATE OF CERTIFICATION (Print or Type)
MAY 1955

14. SIGNATURE OF PHYSICIAN (Print or Type)
J. H. HARRIS

15. SIGNATURE OF REGISTRAR (Print or Type)
J. H. HARRIS

BUREAU V. S.

NOV 30 1955

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE FACTS AS TO THE DEATH OF THE DECEASED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE CERTIFICATE OF DEATH IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE FACTS AS TO THE DEATH OF THE DECEASED.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 22 Film 190 12-27-55 et

10756

CERTIFICATE OF DEATH

11891

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Faulkner				TOWN Faulkner		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
SHIRLEY ANN THOMAS				Nov. 10, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
F	C	Single	8-16-55	3	3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Infant				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Hicks				Mary Alice Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				Mary Alice Thomas, Faulkner, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1 week			
527.2 IMMEDIATE CAUSE (A)				Respiratory infection			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				all her life			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 4, 1955, to Nov. 10, 1955, that I last saw the deceased alive on Nov. 8, 1955, and that death occurred at 11:00 a.m. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
2. M. Johnson				La Plata, Md. 12-17-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				11-12-55		St. Marys	
24. REC'D BY REGISTRAR				LOCATION (City, town, or county) (State)			
REGISTRAR'S SIGNATURE				NEWPORT, Md.			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
DATE 12/22/55				Archart Funeral Home, La Plata, Md.			

2085192395

CERTIFICATE OF DEATH

Page 1 of 1

<p>1. NAME OF DECEASED</p> <p>George H. H. H.</p>		<p>2. SEX</p> <p>Male</p>	
<p>3. AGE</p> <p>45</p>		<p>4. DATE OF BIRTH</p> <p>1910</p>	
<p>5. PLACE OF BIRTH</p> <p>Washington, D.C.</p>		<p>6. OCCUPATION</p> <p>Engineer</p>	
<p>7. MARITAL STATUS</p> <p>Married</p>		<p>8. DATE OF DEATH</p> <p>1955</p>	
<p>9. CAUSE OF DEATH</p> <p>Heart Disease</p>		<p>10. PLACE OF DEATH</p> <p>Home</p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p>John Doe</p>		<p>12. SIGNATURE OF REGISTRAR</p> <p>John Doe</p>	
<p>13. SIGNATURE OF WITNESS</p> <p>John Doe</p>		<p>14. SIGNATURE OF WITNESS</p> <p>John Doe</p>	

BUREAU V. 21

1955

RECEIVED

2007041254

This certificate is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 12th day of April, 1955.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10759

10757 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH COUNTY <u>Charles</u> <u>Lutkata</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St Mary's</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Avenue</u> <u>18X-2</u> STREET ADDRESS (If rural give location) <u>Phys. Men's Hop.</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES OAKLEY TIPPETT</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>11 28 55</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.D.</u>	8. DATE OF BIRTH <u>10-5-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Webster Tippet</u>		14. MOTHER'S MAIDEN NAME <u>Mary Handcock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT & ADDRESS <u>Mrs Bernadette Simpson Charlotte</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>177X IMMEDIATE CAUSE (A) C.A. - PROSTATE</u>		18. MEDICAL CERTIFICATION <u>INTERVAL BETWEEN DEATH AND DEATH 1952</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>11-19 1955 11-28 1955</u>		21e. HOW DID INJURY OCCUR? While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>11-19 1955</u> to <u>11-28 1955</u> , that I last saw the deceased alive on <u>11-28 1955</u> , and that death occurred at <u>M</u> from the causes and on the date stated above. SIGNATURE <u>E. J. Edelen</u> M.D. ADDRESS <u>Lutkata Md</u> DATE SIGNED <u>11-28-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/1/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>Bushwood, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11/30/55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. C. Mattingley</u> ADDRESS <u>Leonardtwn, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10758

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF DEATH

CAUSE OF DEATH

SEX

TIME

NAME OF PHYSICIAN

NAME OF FUNERAL HOME

NAME OF HUSBAND

NO

13

BUREAU V. S.

DEC 2 1955

RECEIVED

Baltimore

James H. H. H.

12/2/55

12/2/55

Don. A. H. H.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10758 **CERTIFICATE OF DEATH**

10760

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>KEECHLAND, POPES CREEK</u>		<u>40 years.</u>		TOWN <u>Rural, POPES CREEK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>KEECHLAND FARM 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>WILLIAM CARLYLE TURNER</u>				<u>NOV 28</u>		<u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>4-27-1891</u>	<u>64</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>BANKER</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ROBERT H. TURNER</u>				<u>UNKNOWN Mary Keech</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>218-14-3291</u>		<u>FRANK K. TURNER</u> <u>MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY thrombosis</u>						<u>10min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ARTERY DISEASE</u>						<u>4 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>---</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>---</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u>, 19<u>48</u>, to <u>28 NOV</u>, 19<u>55</u>, that I last saw the deceased alive on <u>28 NOV</u>, 19<u>55</u>, and that death occurred at <u>12:08 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wooddy</u>				DATE SIGNED <u>28 Nov 55</u>			
				ADDRESS (Street, city, town, state)			
				<u>La Plata, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/1/55</u>		<u>TRINITY</u>		<u>NEWPORT</u> <u>MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 12/3/55</u>		<u>Julia H. Boney</u>		<u>THE HUNTT</u>		<u>Waldorf, Md.</u>	
				<u>FUNERAL HOME</u>			

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RECEIVED
DECEMBER 6 1955
BUREAU V. 1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1. NAME OF DECEASED ROBERT H. TURNER		2. PLACE OF BIRTH BALTIMORE, MARYLAND	
3. SEX MALE		4. AGE 42	
5. OCCUPATION ENGINEER		6. CAUSE OF DEATH HEART DISEASE	
7. DATE OF DEATH NOV 21 1955		8. PLACE OF DEATH HOME	
9. SIGNATURE OF DECEASED (None)		10. SIGNATURE OF WITNESSES (None)	
11. SIGNATURE OF PHYSICIAN (None)		12. SIGNATURE OF REGISTRAR (None)	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles.</i>		MARYLAND		STATE <i>MASS.</i>		COUNTY <i>58X-3</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>La Plata.</i>		LENGTH OF STAY (In this place) <i>36</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>New Bedford - rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physicians Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i></i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>EVERETT A WHITE</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>NOV 27 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>CS-white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>8-26-1888</i>	9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mechanical</i>		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Alden White</i>				14. MOTHER'S MAIDEN NAME <i>Anne Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT & ADDRESS <i>Mrs Bernice White New Bedford, MASS</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <i>Respiratory failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>12 hr</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cerebral vascular accident</i>						<i>36 hr</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i></i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i></i>							
19a. DATE OF OPERATION <i></i>		19b. MAJOR FINDINGS OF OPERATION <i></i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <i></i>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <i></i>			
22. I hereby certify that I attended the deceased from <i>26 Nov 1955</i> , to <i>27 Nov 1955</i> , that I last saw the deceased alive on <i>27 Nov 1955</i> , and that death occurred at <i>4:35 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>J. Wooddy</i>				ADDRESS (Street, city, town, state) <i>La Plata, Md.</i>		DATE SIGNED <i>27 Nov 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>11-28-55</i>		NAME OF CEMETERY OR CREMATORY <i></i>		LOCATION (City, town, or county) (State) <i>New Bedford, MASS</i>	
24. REC'D BY REGISTRAR <i></i>		REGISTRAR'S SIGNATURE <i>Julia H. Boney</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>		ADDRESS <i>Walden, Md.</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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Cheser
Laputa
Physicians Home and Hospital
30

Mass
New England

Male
Everett A
WHITE
Nov 27 1922

Engineer Mechanical Mass

Miss Green

Miss Brown

Cardinal
Laboratory for
St. Louis

BUREAU V. S.

RECEIVED
NOV 30 1922

Recorded

UNCLASSIFIED